Psychological Stresses of Urban Living:
New Directions for Mental Health Services in the Inner City*

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To a large extent, the black inner city demonstrates some of the characteristics of the wider society: the unequal distribution of goods and services, alienation and disorganization, high population density, and dispersion of social responsibility. Nevertheless, the over-riding features of the black inner city are a direct or indirect manifestation of the institutionalized racism that is fact and fabric of American life, altered and affected by individual and group efforts to cope with this destructive force.

Black men in inner cities come from north and south, from farm, small town and metropolis. Comprising several classes, ranging from the relatively comfortable to the growing middle-class, from the large number of working-class and the increasingly large numbers of the under-class (those who have never been able to move to the ranks of the regularly employed, even in marginal occupations), they have differences in life experiences, expectations, and styles of living. They move with varying degrees of restriction both within the ghetto and within the wider city. They have all experienced the direct or indirect effects of racism, discrimination and prejudice.

The multiple barriers which they face are not conducive to self-actualization. As one of the most economically deprived groups in the nation, blacks lack many of the material resources needed to perform their parental tasks successfully. The complex results of the historical determinants of present-day American life, the social reality of that life for the black family, and psychological effects of the external stresses experienced by most black people today—stresses of discrimination, segregation, poverty and racism—all these are interwoven to influence the growth and development of the black individual and the black community.

Yet, the result of coping with what has been essentially disadvantage and adversity has not been entirely negative. Countless numbers carry on their lives without succumbing to the family disruption, alcoholism, addiction and mental illness which exist to a disproportionate degree in the black inner city. Such evidence of the strength of black survival becomes a relative victory when measured against human loss.

The repeated exposures to traumatic experiences —accidents, addiction, malnutrition, disease—are played out against a background in which socio-economic and political forces contribute to a staggering waste of human resources. Generations of black children grow from malnourished infancy to poorly educated childhood, from unskilled youth to unemployed adulthood, often without the inner strength to cope successfully with their deprived environment or the wisdom to see its true causes. Many flee from the unsuccessful efforts to face a troubled reality into unreality of mental illness, the slow death of drug addiction or the aimless existence of the alcoholic street corner society. Suicide increases to become a leading cause of death among young black men. Jails and detention centers are filled with black youth, many of whom have crossed the thin line between hustling to survive and self-defeating, anti-social aggression and crime. Black women succumb to generational dependency induced by a restrictive labor market, economic scarcity, and limited opportunities for meaningful emotional gratification.

The communities in which this struggle for life is carried on are those with the lowest per capita income and the highest admissions to psychiatric hospitals. High rates of public assistance reflect not only the elderly, the ill, the one-parent family, but also those marginally employed heads of intact

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families. Deteriorated housing, owned by absentee landlords, and the big business of narcotics, controlled by outsider profiteers and protected by police and politicians, make victims of slum ghetto residents. Unemployment results not only from discriminatory hiring and advancement practices, but by exclusionary practices of labor unions as well. Contributing to the perpetuation of this situation is a school system which induces underachievement and miseducation and produces the drop-out or pushout, while failing to instill motivation, teach skills or require task orientation. With the press of urban migration from the south, thousands of persons move into inner cities each year, unaccustomed to urban life, experienced in ways that cannot be used in the city, and lacking in basic literacy. As a senseless war of destruction draws to a close, large numbers of black Vietnam veterans, troubled, disillusioned, often drug dependent, come to the cities, to find that they are unwanted as a group and unneeded in a work force diminished through technology and automation.

And in these cities, a panorama of medical disabilities and diseases, prematurity, high infant mortality and morbidity, mental retardation and functional intellectual deficiency exists side-by-side with a non-system of health care provided in low-status, underfinanced municipal hospitals. Frequently, for all practical purposes, this care is ineffective because its programs of health or mental health address only one aspect of multi-determined problems. Generally such care is sought only in time of illnesses; the maintenance of health is rhetoric for most people.

It has long been apparent to those who attempt to obtain human services in inner cities that there is a need for change in the manner and provision of care. The services that do exist are generally fragmented and inadequate, addressing themselves neither to self-evident deficiencies nor to the demands of local residents to participate in shaping their character. They reflect the limitations imposed by holding fast and unquestioningly to a philosophical framework or to the model developed from it, and are characterized by restrictiveness, rigidity, and inappropriateness to the population to be served. Psychiatric insistence upon a narrow view of the medical model of cure; the ineffectiveness of certain middle-class educational techniques for inner-city pupils; and the malevolent dehumanization of a welfare system based on the assumption that all people would rather cheat for pittances than work for living wages—these are some of the indicators of the failure to consider the way in which human needs interact with social forces in developing services. Underlying all of these narrow views is the idea that man can be compartmentalized into a physical, a social, an economic, and a psychological being, and that none of these selves may ever meet. Hence the individual suffers from an over-emphasis on specialization (in theory); in actuality, services are uncoordinated and lacking in comprehensiveness.

TOWARD A BROADENED VIEW OF MENTAL HEALTH CONCERN

To begin to address these problems, an operational framework must take into account the broadened realm of mental health concern, with planned links with other human services. This socio-psychological orientation considers the multiple, interrelated facets of human behavior—physical, social, economic, psychological. It utilizes the potential contributions of the physical and behavioral sciences for mental health. Such a formulation recognizes the significant transactions between man and the social context. Services are directed, not only to individual social and psycho-pathology, but to individual and group strength, not only toward easing the inner tensions of the identified patient or client but toward aiding the social unit to cope with environmental stresses which may themselves be among the determinants of disability.

In this conception, goals reach beyond those of restoring a previous state of equilibrium, of eliminating symptomatology, or of dealing solely with reality problems. They encompass helping an individual to achieve his own potential, to improve his social functioning, and to relate more effectively to his familial and social environment. This approach seeks to develop innovative measures that not only strengthen integrative intrapsychic and interpersonal forces, but also to circumvent and alter negative external forces. It seeks, further, to encourage the development of competence and power by persons who have been excluded by virtue of factors such as psychiatric label, race, social or economic position.

This orientation sees social dysfunctioning and social coping skills as appropriate to the fields of

human service. Indeed, it sees the generic multi-discipline of human service as integrating knowledge from the fields of health, mental health, education, social services, rehabilitation and other disciplines concerned with mobilizing the potential for growth and the drive to autonomy.

The nature of the stresses of urban living under conditions of poverty is such that concerns of mental health cannot be separated from the socio-environmental aspects of health care, education and employment. Yet this philosophy poses a dilemma. To attempt to address adequately the social and economic factors that interfere with mental health may cause the limited amount of skills and resources available to be diverted to larger problems that have, until now, seemed insoluble. On the other hand, to provide services without recognition of the complicating deleterious effects of social deprivation may be to ignore the root causes of the symptoms with which one could deal. Certainly, these are areas ripe for mental health concern: to understand the effects of feelings of powerlessness and the actuality of powerlessness on the development of self-esteem and coping abilities; to gain further knowledge of the effects of material deprivation on growth, personality development and identity formation; to unravel the conflicting evidence concerning the influence of factors such as race and poverty on the incidence of mental illness.

For example, there does seem to be a consistent finding of a relationship of psychopathology to large discrepancies between achievement and aspiration. The question arises as to whether susceptibility to mental disorder increases with anticipation of, or actual failure to reach, desired goals, with frustration, and with unrelieved and prolonged high levels of stress involved in reaching such goals. These questions have implications for a necessary new thrust toward prevention, particularly within the natural social systems of the black community, the home, the school, the extended family. Knowledgeable as the mental health fields are concerning general principles of child development, and knowledgeable as they can become concerning the strengths of the black family and community, far greater emphasis should be put on a large segment of the population who have been neglected—children, youth and their families, not only those severely troubled, but those going through crises of daily living and periods of adjustment to stress or experiencing adaptational difficulties.

Rather than screening such families out of preventive services and providing care at a later date, once a learning disability has been identified, or a child become functionally retarded, or a youth been placed in a detention center or a foster home, there should be developed at a much earlier stage planned social-educational-psychological interventions in the natural environment.

NEW MODES OF SERVICE DELIVERY AND ORGANIZATION

This formulation requires, however, a conception of new modes of service delivery, systems based on this broadened area of concern, and giving high priority to prevention and rehabilitation. Such a system assumes that plans are made for the human service needs of a defined population, not only those identified as patients or clients by themselves or others. In regard to services defined as primarily mental health and health care, attention is given not only to current needs, but to potential needs through primary prevention.

Hand in hand with this approach is the planning and provision of services on a community basis, not only to ensure that they are both available and accessible, but in order for them to be responsive to locally identified needs and expressed demands. This requires a structure by which these demands may not only be expressed, but by which they can also affect the ultimate provision of funds, the development of policy, and the operation of programs. Ideally, such programs should draw upon the culture and lifestyles of the community and relate to its people, not only as consumers and recipients of service and as staff but as co-planners along with the agencies providing services, with those with supervisory and planning authority and with the makers of public policy with responsibility for setting priorities on a city-wide and state-wide basis.

Mental health services in the socio-psychological orientation differ both qualitatively and quantitatively from traditional services. Indeed, direct service (including psychotherapy and casework) becomes only one of a variety of therapeutic, social and psycho-educational activities. Consultation and education assume a major place beside group and individual psychotherapy. Day treatment programs, diagnostic and training services for the

retarded, remediation, therapeutic residences and group homes, sheltered workshops for the mentally handicapped, rehabilitation programs and activities therapies become no longer the exceptional innovation. Multiple forms of intervention are developed, ranging from the medical, psychiatric, and somato-chemical to social, educational and environmental approaches. A continuum of care; varied modalities and sites of service; organizational structures providing degrees of support-independence; and a variety of residential arrangements are encouraged. Immediate availability; problem-centered responses; family, milieu and group therapies; and short-term interventions are characteristic of this approach. Innovative manpower development broadens the term "new careers" from a static use of mental health workers to creative staffing—professional and paraprofessional—patterns which contribute to improvement in the quality of care.

Equally as important as innovative service programs is the need for new modes of service organization directed toward persons at high risk. Networks of services can reach into communities where deficits are greatest. It is almost a truism that, in urban areas, these are communities where racial and ethnic minorities live. Among the groups at high risk or in great need are the elderly, the poor, children and adolescents; the chronically physically or mentally ill; prisoners and probationers; the mentally retarded, the developmentally disabled, persons with life-time disabilities; the adolescent mother struggling to raise a young child.

Yet, in most instances, public funds and mental health programs have largely neglected these populations. The rush to federal funding for community mental health centers resulted in services from which many high risk groups were excluded; categorical grants were not an answer. In regard to CMHC's, for example, the static concept of a mini-department of psychiatry rigidly incorporating five "essential" components (whether duplicatory or not) became the rule. The building rather than the service was the end-all.

Today some communities which rank high in socio-economic indicators of need lack such programs because they did not have the expertise to develop acceptable applications and public agencies did not provide this technical assistance. Thus, for example, of the six federally funded community mental health centers in New York City only three are located in neighborhoods which rank among the City's top 20 poverty areas.

Others, developed painstakingly by local communities, have fallen victim to the whims of an insensitive, inhumane Nixon administration through the impoundment of appropriated funds. Even the centers which have opened suffer from the time lag between approval and initiation. Thus, programs are locked into structures designed years ago with large numbers of beds when the service needs of today require a greater emphasis on decentralized ambulatory care.

In many poor communities, had the guidelines allowed it, it might have been better to renovate old but basically solid buildings and to strengthen struggling voluntary agencies or to establish community-sponsored programs, linking them with public or voluntary hospitals into a network of coordinated community-based services. This kind of linkage and the creative use of joint public-voluntary, interagency funding and operation can be one direction for the future.

Significantly, this orientation allows consideration of new types of community involvement in the sponsorship and operation of services. There comes to mind the idea of a community corporation, contracting and sub-contracting with hospitals, clinics and other human service agencies. Such an organization for service delivery may have the potential for being more independent of Federal program funding constraints and less subject to the restrictions and rigidity imposed by time-lags between prior commitments to the building of physical plants and the implementation of programs. In regard to community sponsorship, operation and control there should be experimentation within the black community. Neighborhood family care centers, community mental health services, and multi-service centers can be models for program development with consumers, citizens, professionals and paraprofessionals involved in the planning and provision of services.

Broad enough in conception and in implementation to acknowledge the complex interplay between individual strength and pathology and social forces, such programs begin to tap the potential of individuals—both professional and paraprofessional—to help themselves as they help others in new careers in human services.

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An analysis of the National Heart and Lung Institute respiratory device contract priorities was made followed by a national survey of diagnostic equipment in community hospitals for RD. Specific mention of the respiratory intensive care unit and monitoring devices was made in treatment of respiratory failure. The "Weed" problem oriented record system designed to improve patient care and medical orientation has become popular.

New concepts were reviewed with respect to care of the tuberculosis patient with phase-out of the sanitorium short hospitalization in general hospitals and followup in an ambulatory care facility. Discussion of National Tuberculosis and Respiratory Disease Association's "Clinic Study" highlighted the effectiveness in delivery of health care to the tuberculosis patient.

The role of university medical centers was discussed along with disadvantaged minority groups, environmental pollution, inadequate housing and the importance of consumer (patient) and provider socio-economic education to open new channels of communications.

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LITERATURE CITED

1. National Heart and Lung Institute Pamphlet: Survey of Professional Manpower in Pulmonary Diseases, Nov. 1972.
2. National Heart and Lung Institute Pamphlet: Respiratory Diseases Task Force Report on Problems, Research Approaches, Needs, Oct. 1972.
3. New York Times, Feb. 10, 1973.
4. CORNELY, P. B. Community Concern for Total Health Care. J. Am. Dietetic Assn., 60:105, 1972.
5. ANDERSON, R. J. National Tuberculosis and Respiratory Disease Association "L" Letter, dated Feb. 20, 1973.
6. Pamphlet: Physician's Directory of Services for the Respiratory Disease Patient in the District of Columbia, Montgomery County, Prince Georges County and Northern Virginia, Mar. 1971.
7. National Heart and Lung Institute Pamphlet: Survey of Professional Manpower in Pulmonary Diseases, Nov. 1972.
8. National Heart and Lung Institute Pamphlet: A Review and Analysis of Pulmonary Device Needs and Priorities, Nov. 1, 1972.
9. ABRAMOWITZ, S. and M. J. SMALL. A Survey of Pulmonary Function Testing in U.S. Hospitals: Apparatus, Prediction Equations and Normal Values. Lab. Management, 10:18, 1972.
10. WEED, L. L. Medical Records That Guide and Teach. N. Eng. J. Med., 278:593, 1968.
11. Guidelines for the General Hospital in the Admission and Care of Tuberculous Patients. Am. Rev. Resp. Dis., 99:631, 1969.
12. National Tuberculosis and Respiratory Disease Association Pamphlet: A Study of TB Clinics in Three Areas, 1971.
13. YOUNG, R. C., JR. and P. A. GRIFFITH. Tuberculosis Case Finding in the Seventies. J. Nat. Med. Assn., 63:432, 1971.
14. KAMPMEIER, R. H. The Role of Academic Medicine in the Evolution of Universal Medical Care? Sou. Med., 61:5, 1973.
15. CORNELY, P. B. Some Observations on the Role of the University Medical Center. Conference on Special Problems of Child Health in the Ghetto. Howard Univ., Wash., D.C., 1972.
16. GUZMAN, L. The Year of Us All. National Tuberculosis and Respiratory Disease Association Bull., May 1973.

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This approach requires a commitment of social policy to the planned development and funding of effective human services in amounts which begin to meet needs. It requires as well the forsaking of interdisciplinary rivalries and of jurisdictional quarrels among state and city, public and voluntary sectors. Further, it calls for a cooperative participation of the black community not in factional struggles in which all concerned must lose, but rather in a constructive collaboration in which the individual and family gain improved, effective and relevant human services. This is of paramount importance, for such efforts, if successful, may begin to bring to the inner city community as a whole greater control over its own social institutions and a concomitant increase in the sense and actuality of power.